Exploring the key elements required for midwives to develop a new model of postnatal care within an acute care setting

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A thesis submitted in accordance with the total requirements for admission to the degree of Master of Midwifery (Honours)

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April 2012

CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Student

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ACKNOWLEDGEMENTS

Research and writing cannot occur without the support of friends and colleagues. In this preface I wish to extend my gratitude and thank the generosity of many such individuals. Special people from the hospital where the research took place, the university where I learnt about research and at home where I became a stranger.

I wish to acknowledge and thank the midwives who bravely shared their experience of what it was like working at the research setting. To the midwives, I thank you all for sharing your world; your reality, frustrations, dreams and aspirations, and thank you for sharing your precious time.

To dear, trusted colleagues at the research site and in particular Blanka and Tracey, I offer thanks for insights and gems of 'personal knowing' that only those who have been involved in maternity care would understand.

To the Director of Nursing and Midwifery at the research site, for her insight and support for agreeing to undertake this research at her hospital with her midwives and the women accessing the service, to see if there was any other way to provide a better service for women and more job satisfaction for the midwives.

My thanks go to the student meeting each month conducted at UTS, to the coordinators and students who shared their trials and tribulations, for giving of themselves when it was my turn, listening and offering assistance on my work. Special thanks to Vanessa, Felicity and Jane my research student support group which without their unwavering encouragement and providing me with strategies to get through, for which I will always be grateful. To Valerie Wilson, Jackie Crisp and Maralyn Foureur for their support and knowledge gaining a better understanding of Practice Development including their precious time for the workshops they conducted at the university, my thanks for their focused and insightful comments in such a supportive environment.

I wish to acknowledge two institutions that contributed to the research by providing scholarship funding. I wish to thank the NSW Branch of the Australian College of Midwives and the NSW Health Innovations Scholarship Committee. Without their support I would not have been able to carry out as many workshops with distinguished guest speakers, pay for the midwives to run the parenting room or have time out from full time employment to explore, plan, analysis and write this paper. I would like to acknowledge the generosity of the international and national experts who provided their time and energy, getting to the hospital and help us see that it is okay to challenge the system, through sharing their stories about what they had found in their research studies.

To my family and friends as they have put up with a very distracted person at times, one who kept deserting them to keep company with the data, literature and the computer. Special acknowledgment must go to my partner, for without the support and encouragement I was given I would never have completed this degree. Thank you for being so proud of me during what seemed a very long time in a bubble and now I am looking forward to getting our lives back to normal. Again I thank my partner, family and friends for their love and continued encouragement especially with things got tough.

And finally I would like to acknowledge my university supervisors. Without Virginia Schmied, Caroline Homer and Pat Brodie's support, I would not have extended myself and probably not be able to complete this thesis. They shared their vast knowledge and wisdom in a nurturing way, never making me feel like I was a *"just the student."* I always felt appreciated and respected. They offered encouragement and challenge, always tempered with warmth and humour kept my eyes on the 'what could be', not on the 'what is'.

Supervisors: Professors Caroline Homer (UTS) 2010 - completion, Virginia Schmied (UWS), Pat Brodie (UTS) 2008-2010.

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ABSTRACT

Aim

This research aimed to explore the key elements to improve the quality of postnatal care provided to women in a public hospital postnatal ward in Sydney and to attempt to implement a new model of postnatal care.

Background

Reports, internationally and nationally, indicate that women are least satisfied with hospital-based postnatal care when compared with antenatal, labour and birth care. Many researchers have identified the components of postnatal care that women find most helpful however, there continues to be barriers to develop and test innovative approaches or models of postnatal care within hospital settings.

The focus of this project was to try to move the postnatal ward to a culture that is woman and baby centred rather than illness or institution-centred. The development process drew on Practice Development approaches that would enable midwives to facilitate change in the environment and culture of the postnatal ward with a view to improving postnatal care for women and their families.

Method

A qualitative descriptive study, using a three phased approach, was adopted for this research. Phase one was to identify the issues and concerns by conducting focus groups with staff. Phase two challenged usual practices and explored new ways of providing care in the postnatal ward. This phase incorporated working with the staff utilising Practice Development approaches. The third phase explored with key stakeholders the outcomes and issues of phase two including the barriers and limitations to enable midwives to implement a new model of postnatal care.

Findings

There were a number of barriers for change to occur including the current system of maternity care provided to women. This has also been reported by others over the past few decades. Within an acute care hospital environment, the midwives struggled to provide quality midwifery care with a philosophy of care counter to that which had been imbedded over many years. Midwives were caught up managing the day to day issues and most were unable to reflect on the care women received or to have the time to contemplate changes.

Challenging the usual rituals and routines with the midwives generated some attainable changes that included providing women with more information about what to expect following birth and updated policies for healthy women and babies. The policies reflect the latest evidence and a more woman and baby centred approach to a daily assessment. This research also explored ways for midwives to be able to spend more time with women, and included challenging the everyday non-midwifery tasks undertaken by midwives working within the hospital system. These non-midwifery tasks included managing administration, security, catering and domestic duties.

Barriers towards providing a more woman and baby centred way of providing postnatal care included the need for further professional development of the midwives and more professional support. There was also a need for role modelling of woman-centred approaches to care and the development of a different way of providing care that included midwifery continuity of care.

Conclusion

Maternity services in hospitals have been subsumed into the general wards often governed by sickness priorities and it is acknowledged changing to a more woman-centred approach was challenging. Without support from leaders, the change towards a woman-centred approach may not happen within the constraints of the medicalised model.

Implications for Practice

My research found a number of implications for others planning improved postnatal care for women in an acute care setting. Key elements included the need for midwives to have a clear articulation of their vision for the ward. Change may not happen if midwives do not believe the benefits of providing individualised care that meets the needs of the women. For this to be realistic and achievable, strong visionary leadership is key to moving the ward vision forward and implementing a new model of care.

The timing for change in this setting is critical. It is unreasonable to implement change with midwives during a period of restructure. This can have a negative impact on successful change by threatening the midwives personal sense of control.

In summary, this research found that effective leadership, adopting a shared vision, providing high support and high challenge were all important elements to support moving towards a more woman-centred care approach. Threatening the midwives sense of control over their professional world was also found to be an important factor when attempting to bring about change and will be discussed in this thesis.

PROLOGUE

Motivations for the new role as researcher

Part of my new role as the clinical midwifery consultant in a busy metropolitan hospital's maternity unit was to develop midwifery models of care and support midwives to provide quality evidence-based care for women and their families. Whilst engaging with the midwives at the research site, I became aware of their frustrations. The midwives were concerned about the lack of quality of midwifery care they were providing the women.

I was, therefore, compelled to work with the midwives to explore the key strategies to develop a new model of care that met the needs of the women, the institution and the midwives. I commenced a Masters of Midwifery honours degree in 2008. My research journey of developing a new model of postnatal care is described in this thesis.

What I bring to this research project

I started my career in health as a nurse and later became a midwife. I have had a variety of experiences as nurse and midwife included being a manager, researcher and midwifery consultant.

In the 1980s I commenced midwifery hospital training and found similar hierarchical structure within the maternity system as I had experienced as a nurse in the general wards. During this period, technology was highly regarded. I was working in an environment where technology was thought to be superior to achieving better birth outcomes (Cragin & Powell-Kennedy 2006). At my training hospital, approximately 70% of women chose to have a private obstetrician and, as a consequence, many were subjected to unnecessary interventions. There were also limited opportunities for me to practise the art of midwifery and there were no opportunities to develop professional relationships with women within this medicalised system.

Working in this medicially dominated environment with limited support for the midwifery profession, I learned quickly, as a way of survival, not question rituals and routines. These traditional practices prevailed in an environment where midwives were disempowered to challenge practice. In the 1980s there were limited opportunities for midwives to provide midwifery continuity of care or be able to work in all areas of the maternity spectrum of care.

A turning point occurred following a conference I attended in the early 1990s in Sydney. The organisers of the conference explained their new team midwifery model of care by asking the midwives to describe the day in the life of a team midwife. These midwives were able to work autonomously, they were able to practice midwifery as defined by ACM (Australian College of Midwives 2006) and the care was focused on the woman rather than the institution.

As a midwife I am passionate about providing women with quality care, from midwives in respectful manner. The conference was a turning point in my career and ever since I have been actively involved in supporting midwives to move from medicalised models to midwifery models of care.

My bias towards the postnatal ward system

Childbirth a profound life event (Lavender & Walkinshaw 1998) and the experience should be powerful and rewarding, with care that focuses on placing the woman at the centre. My passion for woman-centred care and my feelings of frustration when women are not being provided with quality midwifery care undoubtedly influenced this research. Others have described this phenomena. For example, Patton (1990) describing fieldwork and observational research, identified that personal and professional experiences shape your view of the world which may influence the research process and outcomes. I, therefore, acknowledge that my professional experiences over the past 34 years in health, with the last 26 years as a midwife often providing midwifery continuity of care, have to some degree influenced this thesis.